

LESSONS FROM FPMD

**DECENTRALIZING THE MANAGEMENT
OF HEALTH AND FAMILY PLANNING PROGRAMS**

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Executive Summary

Many leaders in the public sectors of both developed and developing countries and in large non-governmental organizations (NGOs) view decentralization as a significant path to improving the access to, and quality and efficiency of health and family planning services. Thus, decentralization is not a goal, but a means to an end. Yet, its impact on services and its success in reaching the goals set for it are rarely evaluated and few opportunities exist to learn from the experience of others.

Lessons from the country-level experience with decentralization that Management Sciences for Health (MSH) has gained through its projects and the experiences of the authors are documented from several countries: Bangladesh, Ecuador, Honduras, Kenya, Madagascar, Nicaragua, Papua New Guinea, the Philippines, Sierra Leone, and Swaziland. The focus of this monograph is to share practical experiences, rather than to provide a theoretical discussion. It is intended for leaders of health and family planning programs, key officials of donor agencies, and planners responsible for the implementation of decentralization.

This document does not assume the existence of or the potential for a single prescription for the “correct” way to decentralize. Instead, it identifies the factors that are affected by introducing decentralization, and suggests ways that decentralization should be instituted in order to improve health and family planning services. The first section provides a brief review of commonly used categories for forms of decentralization (deconcentration, delegation, devolution, privatization, decentralization through local bodies, and federalism). An analysis of key lessons from the field that includes numerous illustrative country examples follows. A rational planning process for introducing decentralization is described next, followed by a discussion of factors enabling decentralization to succeed. The monograph concludes by proposing key issues for future analysis and debate.

Key Lessons

MSH’s country-level experience with decentralization revealed the following key lessons:

Lesson 1: *Decentralization is a political issue* that commonly arises from political pressures outside the health sector. Only rarely is the health sector itself spearheading the decentralization efforts and even where it does, many central-level health and family planning managers actively resist the transfer of power.

Lesson 2: *Guiding principles for decentralization policy are often lacking.* Managers who have the responsibility to implement decentralization must be able to rely on guiding principles. These principles should include the decentralization’s purpose, rationale, objectives, and implementation design, and include a clear definition of roles for the various management levels and the linkages between them.

Lesson 3: *Some functions should not be decentralized.* A function should not be transferred to a lower level if it is critical to the attainment of central-level goals and its sustainability at the local level cannot be guaranteed, the capacity to perform the function does not exist at the lower level, or undertaking this function at the peripheral level is not cost-effective.

Lesson 4: *National leaders and donor organizations often do not appreciate the complexity of decentralization.* Fund flow mechanisms, procurement systems, and human resource management processes are three key areas where this complexity is most prominent. If details of these management systems are not clarified in advance, the success of decentralization is seriously jeopardized.

Lesson 5: *Legal and/or regulatory implications are frequently unanticipated.* The transfer of power can have profound implications with regard to existing laws and regulations, or even be in direct conflict with them. These implications may not manifest themselves until the implementation of decentralization is well under way.

Lesson 6: *Maintaining a consistent policy direction is a challenge* because the number of powerful stakeholders with differing goals increases, local political interests may become paramount in priority setting, local government officials may be subject to rapid turnover, a fragmented or weak central level may fail to coordinate multiple donor projects, and related functional areas may have decentralized to a differing degree.

Lesson 7: *Changing the role of the central level is difficult, but essential.* Too little attention is given to building the capacity of the central level for evolving into its new role. This leads to increasing conflict with the local management, and slows the establishment of clearly defined national standards and guidelines. Central-level staff should be developed to act both as technical program specialists and as general management advisors to the lower-level managers.

Lesson 8: *Clear standards and norms are essential for equity and quality.* The transfer of extensive powers to more peripheral management levels without a system that balances central and local priorities will have a great negative impact on national equity. Quality may suffer due to inexperienced managers, inappropriate local decision making, or duplication of functions. Clear national standards and service norms and an ongoing system of monitoring are essential for guarding both equity and quality.

Lesson 9: *Resources are often not commensurate with decentralized responsibilities.* Decentralization is not cost-neutral. The central level is frequently either reluctant to relinquish the control of funds, or the funds actually released to the local level are insufficient to meet the demands of transferred responsibilities. If past imbalances in service provision are to be redressed, central-level budget resources must be shared between decentralized units using explicit criteria that consider equity and disease burden differences.

Lesson 10: *Broad participation is needed for local progress.* The best managed local health units are those that involve as many key actors as possible in planning for decentralization and in its implementation. This requires establishing effective working relationships between government health and population staff and such key stakeholders as local government chief executives and their planning, financial, and general services staff, local legislators, religious leaders, community representatives, and heads of locally active NGOs.

Lesson 11: *Management training needs are greatly increased.* The transfer of power places a considerable management burden, especially on the lower levels. Yet, in many countries, qualified health managers are in very short supply. Thus, new responsibilities are thrust upon ill-prepared managers who are later blamed for failure. The existing management training capacity is also frequently insufficient to meet the rapidly expanding training needs.

Lesson 12: *Creative local solutions should be disseminated, but generally are not.* Decentralization is expected to increase local initiative in finding creative solutions to problems. Many countries and organizations, however, fail to provide regular opportunities for the managers at the decentralized level to learn from

each other and to share experiences.

Lesson 13: *Monitoring and evaluation yield results, but are rarely done.* The lack of monitoring and evaluation of the impact of decentralization is pervasive. When it occurs, it is often done as an afterthought once the decentralization process has begun, without any baseline data to compare later findings with. Where local progress is closely monitored, a new “culture of accountability” has begun to develop.

Planning for Decentralization

A rational process of planning for decentralization is described as a sequence of logical steps. In the real world, many of the planning steps take place simultaneously, some are hurried and incomplete, and others are totally overlooked. Failing to pay adequate attention to any one of these steps can, however, create considerable problems later.

Assess motivating forces. A clear understanding of why the decision to decentralize was made and by whom must form the foundation for planning for decentralization. Awareness of the political environment and potential allies and enemies of the decentralization process equips health and family planning managers to seek the best fit between the design of the decentralized management systems and their program goals and objectives.

Establish realistic goals, objectives, and expected results. General statements of good intent must be translated into unambiguous goals and objectives for what the government or the organization intends to achieve through decentralization. Neglecting this important step may seriously weaken the provision of health care and family planning, and, ultimately, the health of the people in the countries concerned.

Define “decentralization” in the context of your own organization. Decentralization exists along a continuum that provides a range of possibilities for defining the central versus local balance. Defining decentralization requires making decisions about its geographic, sectoral, and functional scope, the powers to be transferred, the new recipients of these powers, and their respective roles. It is critically important to distinguish between the *responsibility* to manage the programs, the *authority* to make decisions on resource allocation and expenditure, and the *accountability* for financial and program performance, and to link these three different types of powers as closely as possible.

Modify the legal and regulatory framework. The legal or regulatory framework used to implement decentralization dictates to a large extent the ease or difficulty of changing or modifying the power-sharing arrangements in future years. Careful thought must thus be given to the legal and regulatory instruments that are utilized to implement the chosen form of decentralization. Planners should also attempt to anticipate potential areas of legal dispute between the old and the new laws and regulations.

Revise or design new management systems, processes, and linkages. The new or revised management systems, processes, and linkages must promote the achievement of program goals. Such new or revised systems are required, for instance, for planning, budgeting, human resource management, and management information. If equity is a key aim, high priority must be given to building appropriate mechanisms for balancing local and national priorities. To ensure that decentralization does not fragment public-sector service delivery, linkages must be defined between program management levels, between central government ministries, and these ministries and NGOs, and between local government structures and the health program structures. Finally, management processes must be designed to facilitate donor coordination and for hospitals as an effective support to primary health care.

Estimate financial and human resource costs. Decentralization does not become a reality without incurring considerable human and financial costs. The magnitude of costs is a reflection of the form of

decentralization to be implemented, and the level of existing management capacity and infrastructure. A critical step in planning for decentralization is to examine whether the financial, human, and material costs of transferring power and of managing a decentralized system and its components are supportable given the planned level of available resources.

Phase in decentralization. The functions that are being decentralized do not have to be transferred simultaneously. Decentralization can be phased in either by management levels or by functions over time. Functions can also be phased in sequentially, with some functions shifted to the peripheral level first, other functions later. Some functions should never be decentralized.

Train management staff at all levels. Managers in a decentralized system need increased skills in planning; budgeting and financial management; human resources planning and management; staff supervision; logistics management, maintenance and procurement; quality assurance; data processing, analysis and interpretation; program monitoring and evaluation. Strengthening the central-level capacity to undertake management training is almost certain to emerge as a key priority. Adequate preparation for skill-building for managers at all levels includes planning for both short-term management training and for continuous education of health staff.

Keep people informed and resolve conflicts. Successful decentralization requires a sustained commitment and collaboration by those responsible for planning, implementing, and supporting it. Finding ways to nurture such commitment and collaboration is critical. Also important is building appropriate avenues for conflict management because they reduce the likelihood of major confrontations that can sour relationships and undermine services for many years to come.

Monitor, evaluate, and refine the decentralized system. Monitoring and evaluation are essential components of good management. Leaders in the health and family planning sectors who are planning or implementing a decentralized health system must insist that the process incorporate a systematic method of monitoring and evaluation. The evaluation findings must be subject to open debate by all central and peripheral-level stakeholders and used to adapt the system to best meet the program goals and objectives.

Enabling Factors

Even with the above key ingredients in place, the success of decentralization efforts cannot be assured. Additional enabling factors must be carefully nurtured to secure the gains. These include:

- finding and supporting *committed leaders*;
- *taking risks* to try innovative solutions to management problems;
- developing a *critical mass of committed managers* (not only in the top leadership positions, but also at the middle-management level);
- *basing program management decisions on information*; and
- fostering *political goodwill* through open communication of impending changes and adequate opportunities for participatory decision making.

The Way Forward

Decentralization holds promise for improving the achievement of health sector goals in each country. If it

is not carefully implemented, the proper functioning of the health system will be threatened. To promote decentralization only where it serves health sector goals, governments must have more information concerning the appropriate timing and rate of progress in transferring power and about the sectoral implications of changes in their roles. This requires:

- *refining analytical tools* for assessing and monitoring decentralization;
- *establishing appropriate monitoring systems* to assess its impact on health sector goals; and
- *creating more opportunities for sharing information and experiences* between countries about decentralization and its different models.

Introduction

Decentralization—the transfer of power from the central to peripheral levels—is an issue at the forefront of debate in many countries. Faced with increased pressure toward more democratic forms of government, rising expectations of citizens, and reduced levels of resources, governments around the world are considering or already implementing fundamental changes in their governance structures and the power relationships between different management levels. In the health care sector in developed countries, the main pressures on public resources come primarily from the combination of new technologies and changing disease patterns, reflected by an increase in chronic disease rates, reduced fertility, and growth in the number of elderly citizens. In developing countries, these same pressures are exacerbated by high rates of population growth, changes in disease patterns, and dependence on the public sector for providing for acute care as well as family planning, preventive, and promotive health services.

Many leaders in both developed and developing countries view decentralization as a significant way to improve access to, and the quality and efficiency of public sector health services, within the constraints of limited resources. The same is true for large non-governmental organizations (NGOs). Yet, the impact of decentralization on health and family planning services and its success in reaching the ambitious goals set for it are rarely evaluated in a systematic way. Few opportunities exist for countries or organizations just beginning the transfer of power to learn from those who have more experience with this process. This monograph seeks to contribute to mutual learning by sharing lessons about country-level experiences with decentralization in the health and family planning sectors. It is intended for leaders of health and family planning programs, key officials of donor agencies, and planners responsible for the implementation of decentralization.

The lessons presented in this monograph represent the experience of the authors and their colleagues through their work with Management Sciences for Health (MSH) and other consultancies in the following countries:

Bangladesh	Nicaragua
Ecuador	Papua New Guinea
Honduras	Philippines
Kenya	Sierra Leone
Madagascar	Swaziland

This monograph acknowledges that each country and organization is unique, with its own history, internal priorities, available resources, and political ideology. Therefore, it does not presume to provide a prescription for the “correct” way to decentralize. What is an effective decentralization strategy in one country or organization may not be relevant or feasible in another. Indeed, decentralization is not necessarily appropriate in all situations.

An analysis of decentralization attempts to identify the factors that are affected by its introduction, and

suggests ways that decentralization can improve the effectiveness of health and family planning services. The challenge is to understand what conditions make decentralization effective in some settings and less so in others, and which functions can be decentralized and which cannot. Although the main focus of this monograph is on decentralization in the public sector, many of the same lessons can also be applied to non-governmental organizations.

The monograph is organized into five sections:

- The first section—*Forms of Decentralization*—briefly reviews the commonly used classification systems for the different forms of decentralization and the main premises that underlie this monograph.
- The second section—*Key Lessons Learned*—presents a synthesis of the most important lessons from several countries in which MSH has worked.
- The third section—*Planning for Decentralization*—proposes a rational planning process for introducing decentralization, including a discussion of key management issues.
- The fourth section—*Enabling Factors*—presents those elements that are crucial for decentralization to succeed, but cannot be organized through centralized planning.
- The fifth section—*The Way Forward*—presents the key decentralization issues for debate and future analysis.

Forms of Decentralization

The term “decentralization” describes a spectrum of arrangements for transferring power that vary enormously in scope and intent.¹ Decentralization may involve several government sectors (e.g., health, education, and agriculture), or only the public health or family planning sector. It can occur by shifting the authority for specific management areas within one or two of these sectors from a central office to field offices, or by transferring major governmental authority to a subnational territorial entity, such as a provincial or district government. It can be an abrupt shift of power or evolve through a slow process of local capacity strengthening, which eventually allows the central level to entrust local staff with more power. Decentralization also sometimes signifies that the national government has decided to move certain functions to the private sector. Understanding these variances is important to recognizing the potential benefits and threats of decentralization for health and family planning services.

With such confusion over terminology, attempts have been made to categorize the modes of decentralization. The best known is the classification Rondinelli, Nellis, and Cheema developed in the mid-1980s, which divides decentralization into four types:

- **Deconcentration.** The transfer of some management functions to lower-level field units within the same agency or organization.
- **Delegation.** The transfer of managerial responsibility for specifically defined functions to organizations that are outside the regular bureaucratic structure, and thus only indirectly controlled by the central government.
- **Devolution.** The transfer of power to newly created or strengthened sub-national units of government, the activities of which are substantially outside the central government's direct control.
- **Privatization.** The transfer of specific government functions to private non-profit or commercial organizations outside the government structure.

While the above classification schema is still in frequent use, it is also subject to much criticism. First, no country or organization conforms to any single “pure” category of decentralization, as defined above. Instead, countries and organizations exhibit multiple elements of the different forms of decentralization

¹ Much has been written about various forms of decentralization and their definitions. For further reading, see Collins et al., Mills et al., Rondinelli et al., Thomason et al., WHO, and Wolff et al.

simultaneously. Second, some observers maintain that neither deconcentration nor privatization should really be called “decentralization.” Deconcentration, they argue, is simply a type of field administration that does not shift any substantial authority to lower levels. Privatization, in turn, means that the public sector opts out of service provision altogether, rather than decentralizing powers to a management level that is closer to the client.

Collins proposed a new classification system in 1994, with two additional forms of decentralization. These are decentralization through local bodies (that have mixed central and local or regional representation) and federalism.

- **Local bodies.** These are semi-autonomous units, such as District Development Councils, that are usually subject to central government policies, controls, and financial support.
- **Federalism.** This implies that the area governments derive their powers from the constitution, rather than from the central government agencies.

Premises of Decentralization

Three main premises about decentralization and its implementation underlie this monograph:

Decentralization is not a goal, but a means to an end. The objective of decentralization should be to facilitate the provision of accessible, high-quality and efficient health and family planning services that are consistent with national goals. It should be noted, however, that in reality the end is frequently a political one, and not aimed at sectoral goals. This is discussed below.

Decentralization policies and strategies must be consistent with well-conceived roles and functions of all key actors in the sectors to be decentralized. The process of transferring power must be reinforced by formulating and implementing appropriate decentralization policies and management structures. These policies must define the roles and functions of all stakeholders, and the linkages that bind the key actors into a coordinated health system.

Health systems are comprised of both public and private health sectors. The formally organized and legally established government health system makes up the public health sector. The private health sector, in turn, includes both non-governmental organizations (NGOs) and private providers. The NGOs encompass a diverse group of religious missions, parastatal organizations, local members of international NGOs, such as the Red Cross and the International Planned Parenthood Federation (IPPF), and local community organizations. In some countries, the government has incorporated the health services provided by some NGOs—usually those run by religious missions—into its public health sector through signed agreements. Private providers include both formal and informal practitioners.

The diversity of the NGOs is reflected in their different motives toward the attainment of national health and population goals. The private sector, on the other hand, operates parallel to the government sector. In the absence of policy or regulatory intervention, the private sector serves primarily the financial and professional interests of the providers themselves. The appropriate government role is to establish procedures and mechanisms to reconcile these conflicting interests, while providing the direction for how the public and private sectors will work together to attain the national goals.

Key Lessons Learned

Experience with health and family planning programs that operate under decentralized management systems continues to grow. This section identifies a wide range of decentralization issues that have arisen from MSH's work, and include country examples to illustrate the issues at hand.

All of the issues identified are not relevant to each country; decentralization policies that work well in some countries will not work well in others, while decentralization policies that fail in one country may take root in others. The changing political and economic conditions of each country also affect whether decentralization policies succeed. Thus, individual countries should consider any policy change in light of its appropriateness to their unique historical, institutional, political, and economic circumstances.

Lesson 1: Decentralization is a political issue

Decentralization is a profoundly political process, and inevitably some groups win while others lose. It commonly arises from political pressures outside the health sector, which vary from country to country. Threats to the integrity of the state from local power groups may force the central government to grant local level governments a higher degree of autonomy than before. Where political and economic power is highly concentrated in the capital city, grassroots political movements may emerge to take some of the power away from the center. Economic realities may dictate a need to reform outdated public sector institutions and their management. Donors may push the central government to hand more power to peripheral levels. Decentralization in the

health sector may thus be only a by-product of larger institutional changes.

Rarely is the health sector itself spearheading the decentralization efforts. Even where it does lead this endeavor, many central-level health and family planning managers actively resist the transfer of power to peripheral levels.

MSH found that in many countries, health leaders, particularly at the central level, spent more energy opposing decentralization than working to mold the power transfer arrangements into a new health system that better serves the nation's health and family planning goals.

Lesson 2: Guiding principles for decentralization policy are often lacking

Clearly formulated guiding principles of a decentralization policy ensure that those charged with implementing the policy are familiar with its purpose, rationale, objectives, and implementation design, including a clear definition of roles for the different management levels and the linkages between them. These guiding principles for implementing decentralization should be identified early in the policy-making process. The priorities should include realistic, measurable objectives, and service delivery and financial targets. In practice, MSH found that such unambiguous guiding principles for decentralization

are rare.

A common finding from several countries, including Nicaragua, Sierra Leone, and Swaziland, is the lack of a shared vision about decentralization. Interviews conducted in Sierra Leone in 1993, for instance, showed that central-level managers defined decentralization as gaining control of financial management from the Ministry of Finance, but not necessarily transferring any of these powers to local-level health staff. Provincial health managers defined decentralization as gaining a certain amount of management control over the funds for the local level, while senior physicians defined it as setting up hospital boards, and donor representatives thought of decentralization as increasing community participation.

As part of the policy to decentralize the health sector in Ecuador, a presidential decree was issued in 1991 to decentralize the pharmaceutical system. The central Ministry of Health, however, failed to provide an explicit definition of what pharmaceutical decentralization meant. The roles and functions of central and decentralized levels were not clarified, nor were realistic objectives set for the new drug management system. Four years later, the implementation of the presidential decree had not progressed beyond the political will the decree expressed.

Lesson 3: Some functions should not be decentralized

MSH's experience has shown that certain central-level functions should not be decentralized. First, if a function is critical to attaining national health goals or the organization's key aims and its sustainability at the local level cannot be guaranteed, such a function should be retained as a central-level responsibility. For example, central registration of pharmaceuticals is required to ensure that drugs available in a country serve the nation's health goals and are of good quality. If each peripheral unit had different standards for the registration of pharmaceuticals, the quality and appropriateness of the nation's pharmaceutical supply could not be guaranteed and chaos would ensue as drugs move from area to area.

Second, a function should not be handed to a lower level if this level lacks the capacity to perform the function. For instance, the registration of health professionals requires legal expertise and the ability to assess their qualifications and competence. Such assessment skills are rarely, if ever, available at a local level.

Third, a function should not be decentralized, if undertaking this function at the peripheral level is not cost-effective. For example, biomedical equipment maintenance and pharmaceutical procurement in bulk can be done at a much lower unit cost at the central level.

In 1983, Papua New Guinea decentralized nurse aide training to the provinces as part of its devolution, while retaining other health worker training as a national government responsibility. This transfer was not accompanied, however, by the necessary financial resources. As a result, government training of nurse aides, a very important category of staff in the nation's primary health care system, collapsed. The provinces were either unwilling to use their own funds to subsidize the training of students from other provinces or simply lacked funds with which to continue paying for these training programs. Within the span of four years, the number of government nurse aide training programs fell from 13 schools with 135 annual graduates to 3 schools with 13 graduates.

Lesson 4: National leaders and donor organizations often do not appreciate the complexity of decentralization

Central-level policy statements about decentralization must be translated into the operational reality of management structures, systems, and processes. A common finding from MSH's field experience is that both national leaders and donor organizations regularly fail to anticipate the complexity of this process or the speed with which powers can realistically be transferred. This is particularly true in countries where substantial powers have been devolved to local governments.

Fund flow mechanisms, procurement systems, and human resource management processes are three key areas where the complexity of implementation is most prominent. If details of these management systems are not clarified in advance, the decentralization of health or family planning services is seriously jeopardized.

In the Philippines, where health services were devolved, the salaries of transferred staff and the benefits that were promised them under centrally negotiated labor agreements exceeded the carrying capacity of many local governments. In some areas, physicians salaries were even higher than those of the local government head. These staff members received a less than sympathetic hearing when they raised their concern about not having received the promised benefits on time!

In the same country, such seemingly simple things as opening a local bank account to receive central funds became a major obstacle after decentralization. For instance, in one province, the local bank required a minimum balance for opening an account, while the central level could not send funds until there was an available bank account. Solving this dilemma took several meetings between the local health staff, the local government treasurer and accountant, a representative of the central government's auditing body, and even the local government head himself.

Procurement became a very protracted process in some provinces of the Philippines. Local officials required up to 40 separate signatures before a purchase order could be sent to a supplier. This obviously endangered a timely delivery of essential medical supplies, and eventually the quality of the child survival and family planning services.

Lesson 5: Legal and/or regulatory implications are frequently unanticipated

The transfer of power can have profound implications for existing laws and regulations or even be in direct conflict with them. For example, reassignment of staff to decentralized units has legal and regulatory implications for previous central-level commitments to pensions, salaries, and appointments. Some of these implications may not manifest themselves until the implementation of decentralization is well under way.

In the Philippines, the national family planning program introduced a new, injectable contraceptive, which in one local jurisdiction was unintentionally administered to a pregnant woman. The woman's husband threatened to sue the local staff if the baby was born malformed. The local staff were very concerned about their legal protection against malpractice. They did not know whether the national malpractice legislation that had protected them as public servants of the central government still applied to them as employees of a local government.

When powers over health services were devolved to provincial governments in Papua New Guinea, local health staff could no longer legally enforce national legislation concerning the cleanliness of markets, restaurants, and work places. The national legislation governing these functions was outmoded because it was based on the old roles and responsibilities, and corresponding provincial health laws were not in place.

Lesson 6: Maintaining a consistent policy direction is a challenge

Maintaining a consistent policy direction can become a considerable challenge under decentralization. The number of powerful stakeholders with differing goals increases when substantial powers are handed to lower levels. This often causes an inherent conflict between the greater national good and local priorities, as decentralized level managers, who are rewarded on the basis of their performance in improving locally available services and assets, implement policies that conflict with centrally-defined national sectoral goals. Furthermore, local political interests can influence priority setting at the local level so that

decentralized resources are no longer available in sufficient amounts to support a consistent policy direction.

In the Philippines, the national government identified family planning as one of its main health sector priorities. A provincial governor, however, was opposed to family planning for religious reasons, and refused to allow family planning services in his province to be supported through the MSH project. Persuasion was the only tool the central level could use to have this decision reversed. When this situation occurs, the overall national goal of having smaller, healthier families is compromised.

In the early 1980s, Papua New Guinea devolved its rural health services to the provincial governments under an *Organic Law on Provincial Governments*. In 1995, a central government-led effort to reform the provincial government system resulted in the abolition of this law and the enactment of a new one, the *Organic Law on Provincial and Local Level Government*.

Under the new legislation, provincial health services are funded through conditional grants from the central government. Because church health services are considered an important partner in service delivery and the training of health workers, the government has a national policy to subsidize them. (Churches provide about one half of all primary health services in rural areas, especially in the most remote parts.) A national Department of Finance directive instructs the provinces to pay these church health subsidies out of the conditional grants. Many provincial leaders have, however, ignored this directive and failed to pay the subsidies. By April 1997, churches were facing a catastrophic shortage of funds that forced churches in two provinces to close their health services, and brought many others to the verge of closing.

Maintaining a consistent policy direction is an especially difficult challenge in those devolved countries where frequent, legally mandated elections result in a rapid turnover among local government officials. At the national level, health ministers may change too frequently to keep the political direction of decentralization consistent.

In the Philippines, local government officials are subject to re-election every three years. Thus, the policies promoted by the incumbent party may change with the next election. Health managers working for those local governments where political fighting between parties is intense feel very vulnerable. This lack of continuity has a negative impact on building a consistent program of services.

Consistent policy direction is jeopardized if a fragmented, weak central level fails to coordinate multiple donor projects. Each donor has its own imperatives and priorities that influence the implementation of the projects it funds. If the health sector leaders and donor representatives do not share a clear common vision for the aims of decentralization, donor-funded activities may contribute to developing local structures and systems that are in conflict with each other or with a consistent national policy, or both.

In the Philippines, program planning standards and situation analysis tools for family planning, child survival, and population management were developed under an MSH project. These standards and tools needed to be expanded to cover full women's health and safe motherhood services. These topics are, however, the focus of another donor-funded project. The central level has been weak and fragmented, and may fail to ensure that the new, expanded standards and tools are compatible with the old ones.

Decentralization may occur to a differing degree in related functional areas, creating challenges to consistent policy implementation. This is likely to be particularly true, if the relative roles and responsibilities of different agencies over the functional area are contested.

In the Philippines, a decentralized health service structure is responsible for providing family planning services, while related population education activities are centrally managed through a separate agency, the Population Commission (POPCOM). POPCOM was previously the main provider of family planning services. The loss of this function to the health sector is still a source of resentment for some local staff.

To maintain a consistent policy direction, each agency needs to encourage close collaboration between their workers at the local level, provide technical support to its own staff, and convince government officials at all levels of the importance of population and family planning issues. The differing constituents and supervisory lines of authority that these two agencies possess and the lingering resentment make this a particularly complex task.

Lesson 7: Changing the role of the central level is difficult, but essential

Decentralization involves allocating new roles and responsibilities both for those to whom new powers are given, and for those who previously held them. Both groups must adapt to their new roles, develop new skills, and construct new supportive and regulatory relationships. This shift is particularly difficult for those health systems in which the new role of the center is setting standards, evaluating programs, and providing technical support rather than being the directive authority, the role that the center had prior to decentralization.

A frequent finding from the field is that too little attention is given to building the capacity of the central level for evolving into its new role. The challenge is to get the central-level managers to shift away from a way of working that has been familiar to them all their professional lives to a totally new way of working. Unsupported, these staff (usually the same individuals who held the posts prior to decentralization) continue to act in the same manner as they did earlier. They give orders instead of technical support, and demand data instead of developing standards. This leads to increasing conflict with the local management level, and slows the establishment of clearly defined national standards and guidelines.

In Ecuador, senior central-level managers were never committed to decentralization, although external donors had strongly pushed it. The donor project implemented by MSH brought technical support and additional resources to the local level, allowing the local managers to develop work plans, prepare budgets, and implement planned activities. Because of its lack of commitment to the concept of decentralization, however, the central level provided no additional human resources for the local level to implement its planned programs. All local level work plans and changes in budgets had to be approved by the central level, causing implementation delays of several months. Furthermore, since the central level did not prepare its own work plan and, in fact, had only marginally bought into the work plan process, any centrally planned health activities immediately took precedence over locally planned ones.

In MSH's experience, central-level staff should be developed to act both as technical program specialists and as general management advisors to the lower-level managers. As technical program specialists, they carry the main responsibility for strategic management, which includes both strategic decision making and the development of program standards and organizational guidelines. Difficulties arise during the transition when such central-level staff are expected to carry out their old work responsibilities while simultaneously assuming their new roles.

In the Philippines Local Government Unit Performance Project, MSH allocated a "generalist" technical person, working at the central level, to provide support for each local government area. This person was instrumental in helping the local staff to conduct a situation analysis, prepare the local plan, and document the progress. She provided on-the-job training and was available to answer any questions the local staff had.

This approach proved to be most effective for building local capacity, and provided a continuity of support that the local staff appreciated. MSH noted, however, that this intensive level of support required devoting considerable human resources to this effort from the central level. Furthermore, neither the donor nor the government anticipated that such intensive coaching at the decentralized level would be necessary.

Another finding from MSH's experience concerns the development of new programs or sets of activities. Such innovative programs are frequently funded by donors, and initially managed directly by central-level staff. Their transition from an experimental or introductory phase to an operational reality in a decentralized setting requires an eventual transfer of authority from the center to the local level. MSH observed that central-level staff are often reluctant to give up their exciting program, whereas local health staff may not yet have developed a strong sense of ownership. The transition is thus particularly delicate, and requires great care if the program is to continue to flourish.

Lesson 8: Clear standards and norms are essential for equity and quality

Most countries that are in the process of decentralization declare that their aim is to increase both the equity and quality of available health services. The transfer of extensive powers to more peripheral management levels without a system that balances central and local priorities will, however, have a great negative impact on national equity. Quality, on the other hand, may suffer

due to inexperienced managers, inappropriate local decision making or duplication of functions.

Clear national standards and service norms, and an ongoing system of monitoring are essential for both equity and quality. Without standards for allocating financial and human resources, the central government lacks any rational basis for evaluating the impact of decentralization on the equity of resource allocation. Without service norms, neither central- nor local-level health leaders can assess how decentralization affects the quality of services provided.

In many decentralized countries or organizations, the process of setting standards and norms proceeds at too slow a pace. Furthermore, very little attention is given to establishing an ongoing system for debating central versus local priorities. This is partly due to the unfamiliarity of those at the center with developing standards and norms. But it is also due to the increasing complexity of communicating effectively in a health system where prior direct lines of authority no longer apply.

In Papua New Guinea, no standards for allocating financial and human resources existed at the time of decentralization. Furthermore, the central-level health managers played no role in these allocation decisions because budget and staffing negotiations totally bypassed the Department of Health and, instead, took place between individual local governments and the central Departments of Finance and Public Service. Data collected in 1988, five years after the devolution of power, showed increasing inequities in the distribution of staff and little real effect from central-level efforts to redistribute financial resources. In 1996, the Department of Health observed that "Provincial government funding for health services is uncertain, variable, often unverifiable, and almost always insufficient. While the initial health budget may be adequate, a change of scope or priorities sees the funds used elsewhere."

In the Philippines, health staff at the local government level lacked even basic information about existing family planning service norms and policies. They needed such information clearly transmitted in writing and through multiple channels. The central level was both very slow in formulating new norms and policies for areas where they were lacking, and inefficient in communicating the existing ones.

Lesson 9: Resources are often not commensurate with decentralized responsibilities

Decentralization is not cost-neutral. First, the manner in which central-level budget resources are shared between decentralized units affects the center's ability to address national or organizational health goals. If these resources are divided equally between the decentralized management units, geographically larger or more costly areas are penalized. Even when they are divided in proportional shares based on

demographic or other similar criteria, the division fails to account either for current inequities or for any differences in local disease burdens. Allocation based on previous expenditures maintains previous inequities. Therefore, explicit criteria that consider equity and disease burden differences are required to redress past imbalances in service provision. Their adoption, however, is likely to require an extensive and complex process of negotiation between the different management levels.

In the Philippines, where health services were devolved to cities, provinces and municipalities, the formula used to allocate resources failed to take into account either the health facilities that the local level inherited or the services it was expected to provide. The allocation formula thus created clear “winners” and “losers” among these local government units.

Second, for decentralization to succeed in reaching local health goals, the transferred human and financial resources must be commensurate with the new responsibilities handed to these lower levels. This is not always the case. A common observation from many decentralizing countries is the reluctance of the central level to relinquish the control of funds that it had prior to the transfer of functions. Even when an agreement has been reached on budgetary flows between management levels, the funds actually released to the local level may not be sufficient to meet the demands of transferred responsibilities. Human resources, in turn, may be constrained due to the reluctance of staff members to move to the periphery for personal reasons, such as housing shortages, poor schools for children, or lack of job opportunities for spouses.

Kenya provides an interesting exception to the central-level reluctance to yield financial control to decentralized levels. User fees collected at a Kenyan health facility are allocated so that 75 percent is retained by the collecting facility for areas of critical need such as supplies and maintenance, and 25 percent is allocated to the District Health Management Board for the promotion and expansion of primary health services in the district. These cost sharing revenues are in addition to government allocations, rather than resulting in decreased budgetary allocations. This local retention of user fees has resulted in steady increases in revenue collections, thus providing additional funding for local priorities.

In the Philippines, decentralized-level managers in the underfunded local governments lacked sufficient funds to maintain the previous level of services. They were forced to make decisions that were not in the best interest of an efficient, high-quality health delivery system. For example, many local governments no longer could afford to secure a dependable supply of anesthetic gases for their lower-level health facilities. Lacking such essential supplies, local physicians who possessed the technical skills to do Caesarian sections (and who had regularly performed them before decentralization) now were forced to transfer all such cases to the hospitals at the next higher level.

Lesson 10: Broad participation is needed for local progress

The preparation of local plans for improving health and family planning services and the implementation of such plans requires the participation of a wide variety of important individuals and institutions. These include both the government health and population staff and such key stakeholders outside the health sector as local government chief executives and their planning, financial, and general services staff, local legislators, religious leaders, community representatives, heads of locally active NGOs, and others.

Success in decentralization requires establishing effective working relationships between the health managers and the other stakeholders. The best managed local health units in the countries reviewed for this monograph are those that involve as many of these key actors as possible in the planning for decentralization and in networking soon after its introduction. This allows the local health managers to identify those individuals who can be the most influential and capable allies of the newly decentralized health agencies.

In Bangladesh, a local level (subdistrict) team, comprised of elected community leaders, the local government administrator, and professionals of the government family planning program, work together to plan and deliver family planning services to the community. After a short management training program, they jointly develop a one-year action plan that sets forth the objectives of the program, a detailed plan of activities, a budget, and a method for monitoring program activities.

Team members become more self-reliant and motivated when they are given the responsibility to plan and monitor their own program. In turn, they train others in the community, forging new partnerships and developing a cohesive family planning management unit.

The issue of supervisory responsibility is likely to become problematic if the roles, functions, and hierarchical relationships of health managers and other stakeholders have not been clearly defined.

In the Philippines, health staff in some local government units resented any attempt by the regional office of the central Ministry of Health to monitor their activities or to provide technical assistance.

In Madagascar, regional managers resisted any direct contact between the central level and their service sites.

Lesson 11: Management training needs are greatly increased

The transfer of previously centralized management functions, such as planning, programming, and budgeting, places a considerable management burden on the lower levels. Yet, in many countries, qualified health managers are in very short supply. Thus, it is not at all uncommon that at the time of

decentralization, new powers are thrust upon ill-prepared managers who are then later blamed for failure. If the transfer of power is abrupt, as has been the case in some places, the managers may be particularly ill-equipped to cope with the new demands. Frequently, the existing management training capacity is insufficient to meet the rapidly expanding training needs. As emphasized above, the central-level staff are also often poorly prepared to complement the training through ongoing management support to the lower levels.

Madagascar has begun the process of decentralizing planning, management, and budgetary authority to its 111 health districts. Yet, there are not enough qualified local health managers to serve all these districts. For example, district health officers are often junior medical personnel (some are recent medical school graduates) who have never before supervised more than one health facility nor been accountable for a budget, logistics, or program planning. An extensive training program has been developed to improve management capacity, but given the costly and time-consuming nature of such training, these doctors may not be able to assume their new tasks effectively for many months or even years.

Lesson 12: Creative local solutions should be disseminated, but generally are not

Decentralization is expected to increase local initiative in finding creative solutions to presenting problems. These may include a new way of reaching previously underserved clients, a better system of tracking physical resources, or a new partnering with local educational institutions. Such creative solutions can have great potential for replication in other parts of the country.

Countries or programs that are in the process of decentralizing should provide regular opportunities for the managers at the decentralized level to learn from each other and to share experiences. In MSH's experience, however, this is neglected in many countries, in which sporadic national meetings may be the only mechanisms available for mutual learning.

An example of a successful model is in Bangladesh where peer learning is used to provide management training to local area family planning management teams. A new team, comprised of individuals of varied background, skills and perspectives, is trained together in another geographic area where the family planning program is already well established. This allows the new team to become familiar with the factors that have helped the family planning program to succeed in this area, the obstacles that have been overcome, and the ways in which the local resources are used to achieve program goals.

This mutual learning continues through periodic Program Review Workshops, which bring together eight subdistrict (thana) teams at different stages of development to share their experiences and ideas.

Lesson 13: Monitoring and evaluation yield results, but are rarely done

The lack of monitoring and evaluation of the impact of decentralization is pervasive. When it occurs, it is often done as an afterthought, once the decentralization process has begun, without any baseline data to compare later findings with. Three main reasons contribute to this lack of regular assessment.

- First, as mentioned before, the goals of decentralization are often political. The leaders of the health and family planning sectors commonly fail to articulate these political statements into clear goals and objectives for their own sectors.
- Second, the development of management information systems that are appropriate to the decentralized system regularly fails to proceed with the same speed as the transfer of power. Thus, reliable data may not be available when they are needed.
- Third, the local level may resent any attempt by the central level to assess its activities in the belief that total power now lies at the local level.

A new “culture of accountability” has begun to develop in those countries where local progress is closely monitored. The routine monitoring may be done by the local level or by the central level. In MSH’s experience, local monitoring, combined with a second level monitoring by the supervisory level, is more sustainable than monitoring that originates only from the central level. The monitoring data are also much more likely to be then used by local-level staff to adjust their plans.

In the MSH project areas in Bangladesh, subdistrict-level managers (who include community leaders) monitor the family planning program routinely and intensively. The program performance has improved dramatically as a result of this monitoring and supervision, which is also linked to technical assistance. For example, contraceptive prevalence rates in the participating subdistricts (thanas) have increased by 15 to 20 percentage points within six to nine months of the start of project activities.

MSH staff also trained local family planning workers to analyze and use the data they collected in their registers. This allowed them to monitor their own work and to better deploy the volunteers they supervise, improving performance planning and fostering local accountability.

In the Philippines, the MSH project brought additional external resources to the central level of a devolved health system. This made intensive monitoring of locally developed plans possible. Knowing they would be closely monitored, local government areas proved to be quite successful in meeting the performance benchmarks that had been jointly set by them and the central level.

Planning for Decentralization

Well-planned decentralization that is effectively implemented holds promise for narrowing the gap between people's real needs and the services provided. However, as the many country examples in the previous section have demonstrated, planning for decentralization is often deficient. The process is conducted under extreme time pressure, and key stakeholders in the political, social, and health domains are not involved. Such poorly planned decentralization can do great harm to existing management systems and the health services provided.

The few positive examples and the many mistakes and flaws in decentralization design in the real world yielded valuable guidance about the many steps that are required for a successful transfer of power. Based on these lessons, this section lays out a rational process of planning for decentralization. While the process is described as a sequence of logical steps, it rarely, if ever, proceeds in this way in practice. Decentralization is frequently complex and messy. In the real world, many of the planning steps take place simultaneously, some are often hurried and incomplete, and others are totally overlooked. Experience has shown, however, that failing to pay adequate attention to any one of these steps can create considerable problems later. Everyone who can influence the planning process for decentralization is strongly encouraged to ensure that all of these steps are carefully considered before decentralization is implemented.

Assess motivating forces

The motivation for introducing decentralization greatly influences the form it takes, and the legal instruments adopted to implement it. Thus, it is crucial to establish a clear understanding of why the decision to decentralize was made, and which individuals, institutions, and political bodies made the decision, in order to form the foundation for planning for it. This means asking such questions as: Who are the proponents and opponents of decentralization? Why are these individuals or groups so strongly in favor of or in opposition to decentralization? What benefits are they seeking and for whom, by transferring power away from the center? Who is this transfer going to affect most and why?

Decentralization may be motivated by the central government's genuine desire to improve the responsiveness of its health system to local needs. Local health and family planning managers may promote decentralization to increase community participation in planning and managing the program or to reduce the duplication of services at the local level. As mentioned before, however, the push to decentralize is frequently a political one, and has little to do with sectoral priorities.

Political motivations may be the driving force behind the decentralization decision, even where the publicly proclaimed rhetoric for transferring power is to improve health program performance. The central management level's real wish may be to relocate the financial burden of services to the local level, and thereby, to shift the blame for failing to provide an adequate level of these services.

Understanding the complex web of motivations is essential for planners of decentralization in the health and family planning sectors. Awareness of the political environment and potential allies and enemies of the decentralization process equips these managers to seek the best fit between the design of the

decentralized management systems and the program goals and objectives.

Establish realistic goals, objectives, and expected results

If the health and family planning sectors are to benefit from the proposed transfer of power to lower levels, leaders must couple their appreciation of the diverse motivating forces with a clear consensus of the aims of decentralization for health and family planning services. General statements of good intent must be translated into unambiguous goals and objectives for what the government or the organization intends to achieve through decentralization. Without a clear articulation of such goals and objectives that can be monitored and evaluated, the assessment of the results of decentralization will become very difficult.

In the public sector, few countries have succeeded in defining in sufficient detail prior to its implementation what they expect decentralization to accomplish. Since the motivating forces for decentralization commonly have little to do with narrow sectoral aims, the health and family planning sectors may be swept along in a rapidly moving sequence of events, without adequate time and resources to forge a consensus on decentralization's sectoral goals and objectives. In spite of such difficulties, seeking as much clarity and consensus as possible about the specific purposes of decentralization remains very important. Neglecting this important step may seriously weaken the provision of health care and family planning, and, ultimately, the health of the people in the countries concerned.

Realistic expectations may be established only if the potential problems are known in addition to the potential benefits. Decentralization's potential benefits and the difficulties associated with various aspects of management are illustrated in Table 1. Such reflection on the positive and negative implications of decentralization will facilitate identifying realistic goals and objectives that will lead to the achievement of the desired results.

Table 1

Potential Benefits and Problems of Decentralization		
Activity	Potential Benefits	Potential Problems
Strategic Planning	Greater emphasis can be placed on strategic planning and program performance.	Local ownership or control of the program can conflict with leadership from the central level.
Decision Making	Local decisions can be made more quickly with less bureaucratic restrictions, and are usually more relevant to regional/local needs.	Local decisions may not support the national program goals. Decisions may be strongly influenced by local politics.
Coordination	Central level can pay more attention to improving inter-sectoral coordination and collaboration at all levels.	Too many organizations working at the local level can make coordination unmanageable.
Local Participation	Local-level service providers can participate in the program and coordinate their programs.	Local participants may divert program activities from national goals.
Performance Planning	Local staff can establish performance objectives and be held accountable for meeting those objectives.	Local objectives may not be consistent with national program goals.
Financial Sustainability	Central management level is compelled to seriously address the issue of financial sustainability of individual health programs, as it reduces their subsidization of these programs.	Less money may be available for implementing the program, which can worsen regional and local inequities and compromise the quality and availability of services.
Financial Management	Program coverage can be expanded and local revenue generation can be increased.	Local-level staff may not have the skills to manage finances and/or funds may be misused.

Potential Benefits and Problems of Decentralization		
Activity	Potential Benefits	Potential Problems
Resource Use	Determination of resources needed for health services, logistics, supervision, and information, education, and communication (IEC) can be more appropriate.	Central level may not agree with local priorities and may not be willing to finance local initiatives.
Staffing	Staff recruitment can be done at the local level and within the communities served by the program.	Local loyalties and affiliations may inappropriately influence the selection and promotion of staff.
Super-vision	Supervision can be directly linked to and influence planning at the local level.	Weak supervisory skills may result in mistakes in applying national standards of care.
Service Standards	Central level can focus more on national issues such as service standards and norms, and program evaluation criteria.	National service standards and norms may be inappropriate or non-implementable at the local level.
Client Satis-faction	Services can be more easily integrated or coordinated and better organized to meet client needs and convenience.	Referral systems may break down and outreach activities may be cut if the local government does not have sufficient funds to cover transportation costs.
New Services	Opportunities are greater for developing new or innovative services or service delivery mechanisms.	Inadequate local planning capacities or lack of vision may lead to unrealistic service delivery objectives and strategies.

Define “decentralization” in the context of your own organization

The term “decentralization” does not have a uniform, unambiguous definition, but is used, instead, to describe a wide variety of power-sharing arrangements. As emphasized before, MSH’s country-level experience confirmed that confusion about its meaning is prevalent even among those involved in planning for it. Vague definitions lead to weak plans and ineffective implementation. The third step in planning for decentralization is to delineate clearly what the term means in the particular country or

agency intending to institute it. The more clearly it can be defined, the easier it will be for all stakeholders to understand its implications and to work together to maximize its benefits for the health of the nation or the client population.

Defining decentralization requires making decisions on its scope. First, which sectors or functions will be included in the decentralization? In a public sector decentralization initiative, will only the health and family planning sectors be decentralized, or will other sectoral ministries or agencies also be included? Will decentralization cover only some or all of the functional areas of the decentralizing agency? Will the decentralization include the agency's operations in the whole country or only certain parts of it?

Second, which powers will be transferred, and to what extent will they be shifted to lower levels? If, for instance, financial management powers are given to lower levels, does this also include the full accountability for investment funds? If human resources management is decentralized, do the lower levels have complete freedom to create new positions, and hire and fire without reference to the central level? If logistics management is decentralized, can each management level determine which pharmaceutical drugs it wants to purchase? It is particularly important to state clearly what the central level will and will not do.

Figure 1 illustrates how the extent of the central level's role in strategic and operational planning will differ according to the form of decentralization adopted. Decentralization does not imply a dichotomous state for the country or organization of being either decentralized or not decentralized. Instead, decentralization exists along a continuum that provides a range of possibilities for defining the central versus local balance.

Third, who are the recipients of the transferred powers, and what are their roles? In allocating the new roles, it is critically important to distinguish between the *responsibility* to manage the programs, the *authority* to make decisions on resource allocation and expenditure, and the *accountability* for financial and program performance. These three different types of powers should be linked as closely as possible in the management of an organization.

Responsibility for program management without any authority over resources is ineffective.

Responsibility for program management without accountability for program performance is irresponsible.

Accountability for program performance without authority over resources is grossly unfair!

Figure 1

**Range of Involvement and Control in Planning
Under Different Forms of Decentralization**

The range of authority and responsibility that is decentralized will vary from country to country and from program to program. However, each type of decentralization tends to be characterized by decentralizing (to a greater or lesser degree) specific managerial functions to lower levels. The main planning functions that can be decentralized fall into two broad categories: strategic planning and

operational planning. In general, there will always be some functions for which the authority and responsibility will ultimately stay in the central level. These tend to be in the area of strategic planning, particularly in relation to the national program. Operational planning and program implementation are generally decentralized first. Figure 1 on the following page shows the range of central- and local-level involvement and control in strategic and operational planning that is typical for each type of decentralization.

Figure 1

Strategic and operational planning consist of several activities as shown in the list below. As one proceeds down this list of activities, the amount of central level involvement and control is generally reduced, replaced by a greater degree of decentralized involvement and control. The degree of decentralized control for any of these activities is also affected by the type of decentralization—from deconcentration providing the least degree of lower-level control, to privatization which has the greatest degree of decentralized control. This progression of decreasing central-level control is shown by the diagonal line in the graph.

Strategic Planning

- Formulating policy
- Developing norms and standards
- Program monitoring and evaluation
- Conducting situation analyses
- Setting program priorities
- Determining the cost of services
- Allocating Resources (money, human resources, equipment, supplies, etc.)

Operational Planning

- Conducting situational analyses on a specific geographical area
- Setting program objectives
- Determining activities
- Allocating responsibilities
- Developing time lines
- Drawing up and monitoring budgets

Modify the legal and regulatory framework

The legal or regulatory framework used to implement decentralization dictates to a large extent the ease or difficulty of changing or modifying the power sharing arrangements in future years. Decentralization that has been instituted through a constitutional law is much more difficult to change than decentralization that has occurred as a result of an administrative order. Careful thought must thus be given to the legal and regulatory instruments that are utilized to implement the chosen form of decentralization.

As emphasized before, the transfer of power away from the center may have a profound impact on existing legislation. Drafting new laws and regulations and getting them approved is a lengthy process. The more the planners of decentralization anticipate potential areas of legal dispute, the quicker they can

proceed to get essential legislation passed.

Revise or design new management systems, processes, and linkages

Decentralization places new demands on existing management methods. For instance, the form and extent of the required changes depend on the type of decentralization, with devolution obviously requiring more changes than deconcentration. Planning for decentralization means asking such questions as:

- Will existing planning systems and procedures need to be changed to serve the new, decentralized system?
- Are new budgetary procedures required?
- Do the human resource management systems and procedures need to be revised to fit the decentralized structures?
- How should the management information system be adapted?

By anticipating the range of changes to management systems and processes that decentralization demands, clear priorities can be established for designing new or revised essential management systems that are feasible within the existing resource constraints.

An important area to define are linkages between key institutions that influence the management of health and family planning services. To ensure that decentralization does not fragment public sector service delivery, three types of management linkages are essential.

- First, vertical links must be preserved between the different health and family planning program management levels to maintain the quality and accessibility of services nationwide.
- Second, horizontal links between central government ministries, such as Ministries of Health, Finance and Public Service, and between these Ministries and relevant NGOs are necessary to match the needs of the health and family planning systems with available public and private sector resources.
- Third, horizontal links between local government structures and the health and family planning program structures must be fostered to improve the integration and coverage of local government services.

Poorly planned decentralization can severely fracture these essential linkages, for instance by destroying previously integrated provincial or district health offices, or by severing the referral chain between primary health and hospital services.

If equity is a key aim of the health system, high priority must be given to building appropriate mechanisms into the management system that balance local and national priorities. The new or revised management systems, processes, and linkages must promote the achievement of program goals. This seems self-evident, but developing these elements in detail is frequently given too little attention in the rush to transfer power.

Two other areas that require special attention are hospital services and the planning and implementation of donor projects. Management processes must be designed so that they strengthen the role of the

hospital as an effective support to primary health care, rather than making hospitals the competitors of the primary health care system. Planning and implementation of donor-funded projects is likely to become much more cumbersome in a decentralized health system. They will require increased coordination between central ministries, local government structures, and decentralized health management levels. Transfers of donor funds through central- and local-level budgetary systems and the control of expenditure over these funds can become extremely complex. Finally, the implementation of donor projects will inevitably place additional management and accounting demands on peripheral-level managers, thus further stretching the (frequently weak) management capacity at the local level.

Estimate financial and human resource costs

Decentralization does not become a reality without incurring considerable human and financial costs. This important point is sometimes ignored in the debates that rage about the advantages and disadvantages of transferring power to lower levels. The magnitude of costs is a reflection of the form of decentralization to be implemented, and the level of existing management capacity and infrastructure. A critical step in planning for decentralization is to examine whether the financial, human, and material costs are supportable within the planned level of available resources. Two types of estimates are needed. The first is the one-time cost of the process of transferring power. The second is the recurrent cost of managing a decentralized system and its components.

The expense of the process of reallocating powers includes both financial and human costs. Financial costs include salaries of any new staff posts that might be required, building or renting office space for new peripheral health management units, equipping these units with necessary office equipment and transport, physically relocating staff away from the central office, providing management training for central and peripheral staff, etc. The human costs may include losing some senior, experienced health staff who are unwilling to accept their new role and posting, increased friction between central- and peripheral-level managers, and a loss in morale and productivity, at least in the early phase of decentralization.

In calculating the recurrent costs of the decentralized system, separate estimates should be made for the whole system, and for each decentralized management entity. These estimates should be compared with the current and future resource capacity for the system as a whole and for each of the decentralized management units. If the proposed form of decentralization proves to be unrealistic, the plan for decentralization must be adjusted to fit the available level of resources.

Phase in decentralization

The functions that are being decentralized do not have to be transferred simultaneously. The benefits of phasing in decentralization are fourfold:

- First, it allows for a proper introduction and assessment of decentralized management prior to widespread implementation.
- Second, it facilitates proper training of staff for their roles and responsibilities as a building block for their role in the next phase of decentralization.
- Third, it minimizes opposition to the decentralization effort and does not raise expectations unrealistically.
- Fourth, it allows for modifications to the decentralized management roles and processes, thus enhancing the likelihood of success.

The phasing-in process can be done either by levels or by functions. Phasing by levels should start with the units just below the central level. They are fewer in number, which will make it easier to supervise the process and necessary training, as well as to make any required modifications. The level that has completed the first phase can then serve as a training ground as decentralization proceeds to the next level.

Phasing in decentralization by function can also be done sequentially. Some functions can be shifted to the peripheral level first, other functions later, and, as discussed previously, some functions should never be decentralized. Maintaining a proper sequence in phasing is important. The improper sequencing of related functions may create problems or unrealistic expectations that cannot be met.

Train management staff at all levels

Managers in a decentralized system need increased skills in some or all of the following areas:

- planning
- budgeting and financial management
- human resources planning and management
- staff supervision
- logistics management, maintenance, and procurement
- quality assurance
- data processing, analysis, and interpretation
- program monitoring
- evaluation

For a detailed discussion of the set of skills for managers at central and local levels, see the Appendix, “Managers’ Skill Set for Decentralization,” on page 55. These skills are in short supply in many developing countries. Strengthening the central-level capacity to undertake management training is almost certain to emerge as a key priority in planning for decentralization.

Adequate preparation for building the skills of managers at all levels includes planning for both short-term management training and for continuous education of health staff. Accommodating any additional demands that these training needs may place on existing training facilities and their staff must also be taken into account.

Keep people informed and resolve conflicts

Successful decentralization requires collaboration and a sustained commitment from those responsible for planning, implementing, and supporting it. This includes the central-level staff, such as political leaders, key personnel in the Ministry of Health and other relevant government ministries or in the NGO’s head office, staff at the decentralized program management level, the donor community, and other pertinent NGOs. Yet, if the various motivations for decentralization are in conflict or the forces for and against decentralization wage a fierce battle, sustained commitment may only be precarious, at best. Finding ways to nurture such commitment and collaboration is a critical component of planning for and implementing decentralization.

The general public, clients of the health system or organization, and officials whose activities support the delivery of services must be well informed about the goals and objectives of decentralization, and about the new ways of managing the services. Clients must know how to access the health and family planning services in the future, and what their own role is in supporting the decentralized health system. Officials must be clear about who holds the responsibility, authority, and accountability. Radio talks, public

relations campaigns, seminars, and other such activities can be used to transfer this information.

Finally, some discomfort will inevitably arise in any system undergoing fundamental change. If appropriate avenues for conflict management are built into the decentralized system, these disagreements are less likely to develop into major confrontations that can sour relationships and undermine services for many years to come.

Monitor, evaluate, and refine the decentralized system

Monitoring and evaluation are essential components of good management. Leaders in the health and family planning sectors who are planning or implementing a decentralized health system must insist that the process incorporate a systematic method of monitoring and evaluation. This must include baseline data collection before decentralization, ongoing monitoring of the process of transferring power, and periodic evaluations of the impact of decentralization on national health and family planning program goals and objectives. The evaluation findings must be subject to open debate by all central- and peripheral-level stakeholders, and used to adapt the system to best meet the program goals and objectives.

Vigilant monitoring is particularly important early in the process of implementing decentralization, when both central- and peripheral-level managers are still adapting to their new roles and responsibilities. In this early stage, management structures and linkages are likely to prove much more flexible than later when managerial practices have become established and linkages forged. The opportunity should not be lost to mold them so that they best serve the attainment of program goals.

Enabling Factors

The discussion in the section above presents some of the key ingredients for decentralizing health and family planning programs effectively. But even with these factors in place, the success of decentralization efforts cannot be assured. Additional enabling factors are necessary to secure the gains. These factors cannot, however, simply be “ordered” or “decreed” by central or decentralized authorities. Instead, they must be carefully nurtured as essential ingredients of success.

Find and support committed leaders

For decentralization to succeed, key leaders must have a political commitment to the concept and be willing to see it through all the difficulties of implementation. Where such strong political support exists, the implementation of decentralization is faster and has fewer problems. A strongly supportive local government administrative head, for instance, is a major advantage for running a decentralized public sector health or family planning program.

Take risks

Risk takers who hold key positions in the decentralizing program are essential for it to succeed. These individuals firmly believe in decentralization, and are willing to try innovative solutions to management problems. Such solutions may include, for instance, allowing a certain degree of flexibility with rules and regulations that facilitate program management under decentralization but do not compromise quality.

In many countries and organizations, officials are generally reluctant to be innovative or to allow any flexibility in the interpretation of rules and regulations. They fear penalties for violating the rules, and the impact that this would have on their careers. Wanting to minimize any risk, such officials push controversial decisions upward in the management chain, instead of seeking to solve the problems themselves. Thus, successful decentralization demands a paradigm shift at all levels from defining a good manager as one who faithfully executes orders to one who seeks the best available solution to any given problem.

Develop a critical mass of committed managers

Successful decentralization requires an adequate corresponding management capacity. Appropriate management systems and skills are important, but equally crucial is the existence of a critical mass of committed managers who genuinely want to see decentralization succeed and are willing to work together to overcome obstacles. This critical mass must exist not only in the top leadership positions, but also at the middle-management level.

The number of skilled managers required to run a decentralized health system may be considerably more than in the original system. This is particularly true of devolved countries. If decentralization is to reach its potential of increasing local ownership, this larger group of new, local-level managers must include a sufficient number of those who are truly committed to decentralization. In addition, they must be given the opportunity to meet regularly and exchange experiences.

Base program management on information

Information is essential both for planning for decentralization and for understanding its effects. The full benefits of decentralization are realized only if information is regularly used to establish priorities, allocate resources, and assess results. Hence, managers at all levels must be committed to information-based management if decentralization is to work effectively at all levels.

Foster political goodwill

Decentralization is commonly a response to a political imperative. However, a directive or imperative is not a sufficient condition to ensure the success of a decentralization effort. It must be accompanied by political goodwill among those who design and implement the decentralized management systems and among the clients who use the services. Open communication of impending changes, and adequate provision for participatory decision making are important mechanisms for generating such goodwill, especially where it is endangered by a reluctance to lose power, rivalry between levels of government, or fear of the unknown. In addition, politicians must be prepared to take criticism as the decentralization process progresses and to provide the long-term vision to encourage commitment to this process.

The Way Forward

Improving the general health and welfare of the population has been the traditional role of central governments. For most countries, this includes efforts to facilitate access to needed services, as well as to ensure their quality and their efficient and equitable distribution. While assuring the health of its citizens remains a priority for virtually all countries, these efforts to move toward an efficient and equitable health system now often seek to use decentralization as one means of achieving it.

Planning for decentralization

Each country is unique, and no single prescription for the “correct” way to decentralize exists. What is an effective decentralization strategy in one country or organization may not be relevant or feasible in another. Indeed, decentralization is not necessarily appropriate in all situations.

The stated objectives of decentralization are to bring about fundamental changes in the health system that will help meet national health objectives while making the system financially, organizationally, and politically sustainable. As the specific national objectives vary from country to country, so will the decentralization strategies adopted. While each country is unique in the details of the response its specific situation requires, some basic factors that promote successful transfer of power remain constant. This analysis of decentralization experiences in Bangladesh, Ecuador, Honduras, Kenya, Madagascar, Nicaragua, Papua New Guinea, the Philippines, Sierra Leone, and Swaziland identified the following common factors as the basic requirements for successful decentralization:

Planning for Successful Decentralization

- Assess motivating factors for decentralization
- Establish realistic goals, objectives, and expected results
- Define decentralization for each context
- Modify the legal and regulatory framework
- Design new management systems, processes, and linkages
- Estimate the financial and human resource costs
- Phase in decentralization
- Train management staff at all levels
- Keep people informed and resolve conflicts
- Monitor, evaluate, and refine the decentralized system

The analysis of country experiences also identified some enabling factors that increase the probability of success with any decentralization endeavor. They are the following:

Enabling Factors for Successful Decentralization

- Find and support committed leaders
- Take risks
- Develop a critical mass of committed managers
- Base program management on information
- Foster and facilitate political goodwill

Challenges for the future

The challenges for the future are several. First, there remains the need to understand what conditions make decentralization effective in some settings and less so in others. It is also essential to discern more accurately which functions of health and family planning systems can be decentralized and which cannot. These types of analyses of decentralization are required to identify the factors that are affected by introducing decentralization, and to suggest ways that decentralization can improve the effectiveness of health and family planning services.

Second, the key questions asked by policy makers in deciding whether or not to decentralize must be clear. Effective policy making is essentially pragmatic, seeking to understand how the current system works and why it works that way. In considering the policies for a decentralized health and family planning program, policy makers must:

- Ask how the existing and potential strengths of the decentralized sector can be used to achieve national priorities;
- Identify actions to take to ensure that increased decentralization does not come at the expense of these public priorities;
- Define the level to which decentralization ought to proceed, given the national resources.

If the lessons from the field are not heeded in making these decisions, decentralization can reduce services, increase inequity, weaken the entire health system, and produce programs and health activities that are neither priorities of the community nor consistent with existing health problems.

Third, policy makers must become aware of the unique aspects of health and family planning systems under decentralization. While the theoretical impact of a given policy can be assessed, the actual outcome also depends on other factors within the sector. The actions of other policy makers, with other priorities and interests, affect the ability of the health and family planning sector to meet its own public objectives, and limit its available policy choices to improve sectoral performance. Simply applying national policies for decentralization to the health and family planning sector fails to recognize its special characteristics and strategic priorities.

Fourth, analytic tools must be developed for an improved understanding of decentralization. Decentralization is an evolving process in which the power arrangements of today may well need to be altered in the face of the realities of tomorrow. While the “streams” of decentralization that run through any health system defy static and mutually exclusive definitions, each form implies a very different degree of central versus local dominance. Further refinement of analytic tools will inform the process of selecting the mode or modes of decentralization that will maximize the achievement of the nation’s health goals.

Conclusion

Decentralization poses a complicated set of strengths, weaknesses, opportunities, and threats to the achievement of health sector goals in each country. Countries are diverse in terms of their levels of income; the mix of public and private sector delivery and financing varies, and so do their attitudes and political approaches with respect to decentralization.

In some countries, the private sector has already overtaken the public sector in size and importance in many areas of health service delivery, especially in the delivery of curative or personal health services. Growth in the private sector opens up opportunities for countries to reappraise traditional ways of thinking. They can determine how the health service delivery and financing systems should be reorganized and operated and what public and private sector mix is most appropriate to meet their specific national health sector goals. More research and sharing of experiences is needed regarding the growth and effects of private sector participation in the health sector in the context of decentralization.

The role of government in the health sector is at the heart of public policy as it relates to health sector reform. To promote decentralization only where it serves health sector goals, governments must have more information concerning the appropriate timing and rate of progress in transferring power and about the sectoral implications of changes in their roles. This calls for further refinement of analytical tools for assessing and monitoring decentralization and the establishment of appropriate monitoring systems to assess its impact on the health sector goals.

Finally, the formulation and development of appropriate decentralization policies and regulatory and incentive systems would benefit greatly from much wider opportunities for sharing information and experiences about decentralization and its different models. International organizations and multilateral and bilateral agencies can make valuable contributions by fostering such opportunities and by making available appropriate technical assistance.

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Appendix—Managers' Skill Set for Decentralization

In order for decentralization to work, central- and field-level managers need to have complementary roles and skills. Managers at both levels must master skills in the key management areas that will be most affected by decentralization. Following is a summary of the major skills that managers at the central and local levels must have in a decentralized setting. This skill set is adapted from *The Family Planning Manager*, Volume IV, Number 2, "Decentralizing Health and Family Planning Services," March/April 1995.

Program Planning

The primary role of the central level is to (a) define policy and strategy, (b) develop national policies that define standards and norms and evaluation criteria, and (c) help local-level managers develop the necessary skills in program planning and implementation.

Central-level managers should be able to:

- Make demographic projections and epidemiological analyses, and use those projections and analyses for setting long-range goals and strategies for the national health and population programs;
- Establish national goals for improving the health status of different population groups;
- With the involvement of local-level managers, formulate a national strategic plan that uses research and survey data, is based on realistic objectives and can be implemented at the local level;
- Determine program performance standards in order to achieve national goals.

Local-level managers should be able to:

- Develop operational plans and manage integrated services;
- Analyze clients and services and know how to use the information to make program improvements;
- Set program targets for their catchment areas that are consistent with national goals;
- Create conditions that encourage community members to participate in planning and implementing the local health program.

Financial Planning and Management

When resources are limited, as they usually are, the central level should distribute the resources equitably. Lower levels should be encouraged to raise and manage other resources obtainable at their level.

Central-level managers should be able to:

- Make long-range projections for financial needs, and determine national health financing mechanisms, in collaboration with other relevant agencies;
- Set up systems that allow for funds to be allocated to local levels on an equitable and timely basis;
- Establish guidelines that allow local managers to have access to central, local, and private funds for covering their capital and operating costs;
- Mobilize additional resources from bilateral and multilateral donors to support local initiatives.

Local-level managers should be able to:

- Analyze and estimate service costs, prepare budgets, and manage funds allocated to them by the central level;
- Control expenditures in accordance with accepted accounting practices;
- Identify and initiate new sources of revenue for the programs from local government or private sources;
- Introduce and manage income-generating projects to supplement their financial resources;
- Manage contracts for personnel, transportation, procurement, and other outside services.

Human Resources Planning and Management

The central level must ensure that adequate numbers of trained staff are available, when required. Local managers can determine their own need for staff and assess the quality of their performance.

Central-level managers should be able to:

- Maintain a national management information system on human resources;
- Forecast long-range supply and requirements of human resources for health;
- Develop national staffing standards and apply them to assess the equity of staffing;
- Develop training plans that correspond to the human resources forecasts, and coordinate a network of training resources;

- Ensure that training is of acceptable quality, appropriate and affordable;
- In coordination with other relevant agencies, develop salary structures, terms and conditions of employment, and guidelines for career development that promote the achievement of health sector goals;
- Establish clear procedures for staff appointment, promotion, transfer, performance assessment, and discipline;

Local-level managers should be able to:

- Manage local level human resources using centrally set guidelines and standards, including recruiting, hiring, promoting and transferring staff, assessing their performance, and disciplining them;
- Assess the appropriateness and equity of staffing between facilities and priority health programs, using national staffing standards;
- Assess training needs and develop a realistic staff development plan;
- Operate an ongoing refresher training program;

Staff Supervision

The central level should develop performance standards and training in supervision. The local level should undertake the supervision, because it is more efficient, more timely, and more effective, when conducted at this level.

Central-level managers should be able to:

- Negotiate with professional associations to gain agreement on clinical service standards;
- Communicate these professional norms and standards to all local-level managers;
- Organize and coordinate training programs for supervisors;
- Develop new tools and materials that support the routine tasks of supervisors and encourage innovative thinking and problem solving;
- Review and establish professional standards for key technical and administrative staff involved in service delivery.
- Evaluate how supervision efforts have improved staff and program performance.

Local-level managers should be able to:

- Understand the importance of supervision and allocate appropriate resources for supervisory activities;
- Establish a supervisory system that can be carried out in a timely and supportive manner;
- Establish appropriate guidelines for supervisors to use in solving problems and developing the skills of their staff.

Logistics Management, Maintenance, and Procurement

Because commodities purchased from local sources are likely to be more expensive, there are clear advantages in having the central level manage logistics, procurement and vehicles. This includes the procurement and storage of spare parts and maintenance of equipment. Where the difference in costs is not great, decentralizing logistics and vehicle management to the local level can lead to more rapid and appropriate solutions to problems.

Central-level managers should be able to:

- Set up systems for maintaining stocks and for setting up ordering and delivery schedules that are consistent with local usage;
- Determine when it is in the national interest and most cost-effective to manufacture pharmaceuticals in-country;

- Monitor the efficiency of the entire logistics system, identify problems that can adversely affect timely orders and deliveries, and decide under what circumstances it might be appropriate to decentralize logistics management or to contract logistics out to an outside organization;
- Set guidelines for purchasing vehicles or maintaining and replacing equipment as necessary;
- Provide assistance to local managers in determining minimum stock levels and managing inventories.

Local-level managers should be able to:

- Determine both the appropriate mix of pharmaceuticals and the ordering and delivery schedules that are consistent with local usage patterns;
- Ascertain under what circumstances it would be appropriate to contract with private transport companies for delivering supplies, and negotiate contracts for those services;
- Determine the type of transport that is most suitable for activities requiring travel, such as delivering supplies to health facilities or making supervisory visits, and manage the use of vehicles in the most efficient way.

Quality Assurance

Quality of care standards and policies should be set by the central level. When they are in place, local-level managers can incorporate them into local service policies and standards.

Central-level managers should be able to:

- Establish quality of care standards for the national health program;
- Develop incentives, such as accreditation, to encourage local programs and facilities to maintain high-quality services;
- Analyze and use the results from studies of clinical and non-clinical services and other components of health programs, such as IEC campaigns;

- Determine whether service quality problems are due to poor skills, old or outdated equipment, client attitudes, community relationships, or local politics, and assess the impact of these deficiencies on health program performance;
- Identify solutions to problems and develop general strategies for involving local-level managers in finding solutions and mobilizing resources to improve service quality.

Local-level managers should be able to:

- Adapt national guidelines to local conditions and maintain standards of care in their programs that are consistent with national guidelines;
- Carry out continuous quality improvement (CQI) programs and use the results of their CQI efforts to reorganize services, modify staff functions, revise job descriptions, and develop refresher or continuous education programs to support program performance;
- Incorporate the CQI process in the monitoring and supervisory systems to transform CQI into an essential management system.

Management Information and Program Monitoring
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Local managers should define MIS needs and use the information in planning and implementing local programs. The central level can help the local level by providing guidelines and mechanisms for collecting and analyzing data. Data collected at the local level should be used by the central level to compare program performance, analyze trends, and maintain performance standards.

Central-level managers should be able to:

- Determine a basic set of indicators required for maintaining essential national data, and establish a reporting system so that local managers can easily report these data;
- Monitor the efficacy of the information flow and the quality of the information provided, and update or revise systems as needed;
- Determine the progress toward programmatic goals and when major strategic changes may be necessary.

Local-level managers should be able to:

- Determine the indicators that are useful in planning, monitoring, and evaluating local program performance.
- Maintain the information systems and use the results to plan new or improve current programs.

Program Evaluation

Evaluation should be centralized. The central level should evaluate programs at all levels and undertake a review for the purposes of developing future program strategies. Where possible, local managers should take part in evaluating programs in order to improve local-level program implementation.

Central-level managers should be able to:

- Determine whether local and national program strategies are contributing to the achievement of national health goals;

- Determine what levels of resources are necessary to achieve the goals, and how to mobilize these resources effectively.

Local-level managers should be able to:

- Identify critical indicators that will provide the most useful information on program achievements, including those that relate to program inputs, processes, results and impact.

Both central and local-level managers must be able to understand and use the results of routine monitoring systems and periodic national surveys. They must know how to analyze the results of national surveys, such as Demographic and Health Surveys, Contraceptive Prevalence Surveys, or situation analyses of service delivery. Finally, they must know how to design and implement program changes based on survey results to improve the programs or functions for which they are responsible.